Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Parkview House
Name of provider:	St Michael's House
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	03 September 2018
Centre ID:	OSV-0002406
Fieldwork ID:	MON-0021690

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Parkview House is part of St. Michael's House, an organisation providing services to people with an intellectual disability. Parkview House aims to provide a homely environment where individuals are supported to live as independently as possible and make choices about their lives. The centre provides residential services for four individuals with intellectual and physical disabilities. Regular respite is also provided every second weekend to one service user. The centre consists of a five bedroom bungalow with a separate building on site used as a multipurpose activities room for residents and comprises the separate visitors area. There is a kitchen and dining area which is fully accessible to all residents. There is also a separate sitting room and sun room for individual activities. Parkview House is managed by a Social Care Leader and the staff team comprise of one nurse and social care workers. The centre is supported by a multi-disciplinary team. Access to a psychologist, psychiatrist, social worker, medical officers, occupational therapists, physiotherapist, speech and language therapist, dieticians and specialist nurse supports are available on a referral basis. Parkview House has a mini-bus which is used to transport residents to and from outings and activities of their choice.

The following information outlines some additional data on this centre.

Current registration end date:	15/01/2019
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
03 September 2018	09:00hrs to 18:30hrs	Erin Clarke	Lead

Views of people who use the service

The inspector spent time with all services users that availed of a service in Parkview House. Although a number of residents were unable to tell the inspector about their views of the service they all appeared very relaxed and comfortable in the centre and were observed engaging in their own activities and morning routines supported by staff. The inspector observed that the residents were content with the support provided by staff at the time of the inspection. It was noted that the residents were very familiar with the person in charge and interacted in a positive manner with them. Residents' views were also taken from HIQA questionnaires, the centre's annual review and various other records that captured the views, likes and dislikes of the service user. Four questionnaires had been filled in by family representatives on behalf of the service user and it was evident that families were happy with the the level of care and supports afforded to their family members and satisfied with the activities and facilities available. The inspector observed staff offering and facilitating service users in making choices for breakfast and how to spend their morning. Issues were identified in relation to the compatibility of some residents living in the centre which were impacting upon the lived experience for these residents.

Capacity and capability

Overall, the inspector found that the management systems in place and oversight of the service provision provided quality outcomes for the service users and there was evidence of an effective governance structure and strong leadership in the centre. However, improvements were required in the centres self monitoring systems in relation to the identification and implementation of control measures to mitigate risk and safeguarding concerns as detailed under Quality and Safety.

The registered provider notified the Authority prior to the commencement of the inspection that a change in the person in charge had occurred to facilitate a project in the organisation. This was not notified within the required time frame, however the inspector was satisfied that the centre was replaced with, and managed by a suitably qualified, skilled and experienced person in charge. The person in charge had been in their position 6 weeks at the time of the inspection; they had been employed within the centre as a social care worker for the previous five years with deputy person in charge duties for four years. The inspector found that the person in charge was actively engaged in the operational and day to day management of the centre on a regular and consistent basis. The person in charge worked alongside staff members on the roster which provided an oversight and supervision of the care and support provided to the residents. They demonstrated sufficient knowledge of the legislation and their statutory responsibilities within the regulations. Protected

hours were provided on a weekly basis to ensure that the person in charge could fulfil their roles and responsibilities in auditing and reviewing the quality and safety of the service.

There was evidence of an effective governance structure and strong leadership in the centre. The inspector was satisfied that there was effective communication between the person in charge, senior management and the provider. There was a clearly defined management structure in place, the person in charge was supported in their role by the services manager in who turn reported to the director of operations. The person in charge met with the services manager for one to one meetings and felt supported with regular informal contact. The services manger held cluster management meetings every two months for a number of designated centres that reported into her which facilitated shared learning. Due to being new in the post, the person in charge was scheduled to attend their first cluster meeting in September.

On review of the last six monthly unannounced visit carried out by a person nominated by the provider, it was identified by the inspector that improvements were required in the monitoring of incidents and risk in the centre and the time lines of the visits to ensure that an effective plan to address any concerns were implemented in a timely manner. An annual review of the care and support provided in the centre was completed by the registered provider which reflected the two six-monthly unannounced visits to the centre in the previous 12 months. The annual review identified areas for improvements, non compliance's with the regulations and examples of good practice. The views of residents and their families were evident in the process of the review and staff were promoted to raise any concerns, comment on areas for improvement and reflect on the achievements in the centre. Actions that were identified had assigned time lines and persons responsible for completion of the actions.

There was a number of audits completed in the centre demonstrating a commitment to on-going review and service improvement. auditing and review system in place for resident’s finances, medication, infection control, fire measures and health and safety. An audit carried out of the residents finances had identified proactive measures, that were in the process of being implemented, as additional safe guard measures.

All residents had a signed written contract of services in place, however the contract of care did not accurately reflect the current fees to be paid. Residential Support Services and Accommodation Contributions (RSSMAC) financial assessments had been undertaken which resulted in a reduction of the weekly contribution to be paid by residents from €120 to €70, this had not been implemented into the contract of care for transparency of fees.

Staffing numbers and skill mix was found to be appropriate in this centre reflecting the assessed needs of the residents. Staff spoken with were found to be knowledgeable, professional and caring in terms of their understanding of their role and their duty of care to residents. Whilst there were some gaps identified in the training records, dates had been scheduled for staff to attend. Supervision records

were reviewed and quality supervision was provided that took a holistic approach to reflective practice. Improvements were required to the frequency of occurrence as per the organisations policy. The roster was planned and devised around the identified needs of the residents and was flexible to change depending on the activities and schedules of the residents. The inspector observed practices between staff members and residents and found that residents received appropriate assistance, intervention and support in a respectful, timely and safe manner.

Registration Regulation 7: Changes to information supplied for registration purposes

The registered provider did not notify the Authority within 10 days of the change in the person, nor supply full and satisfactory information as set out in Schedule 3.

Judgment: Not compliant

Regulation 14: Persons in charge

The centre is managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

Staff have received relevant training, demonstrate knowledge and competence in these areas.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had maintained a directory of residents which met the requirements laid out in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents have a written agreed contract of care but details of some charges were incorrect.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre's statement of purpose (14 February 2018) met the regulatory requirements as outlined in Schedule 1. There was evidence of review and revision of this document.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all restrictive practices in use in the centre had been notified in the quarterly notifications to the Chief Inspector. In relation to the incidences of peer to peer safeguarding concerns not notified, this was addressed under regulation 8: Protection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All schedule 5 written policies and procedures were adopted and implemented, made available to staff and reviewed when required.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that an appropriate number, qualification and skill mix of staff were employed to meet the assessed needs of the resident. The person in charge ensured that there was a planned and actual staff rota and it was

appropriately maintained.Staff were familiar with the residents' needs and there was continuity of care with limited agency staff used but improvements were required in obtaining documentation and information as specified in Schedule 2.

Judgment: Substantially compliant

Regulation 23: Governance and management

There is a clearly defined management structure in place that identifies the lines of authority and accountability and responsibilities.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible version of the complaints process available for residents and their representative but it did not contain the detail of the complaints officer.

Judgment: Substantially compliant

Quality and safety

There was evidence that residents received a person centred service and experienced a good quality of life in the centre. However improvement was identified in the areas of safeguarding, risk management, fire precautions and medication management. From a review of the incidents that had occurred in the centre since January 2018 the inspector found that the identification and management of safeguarding concerns required review, in particular the impact of behaviours that challenge on residents in the centre. The inspector had identified five incidents of physical interactions between residents that were not identified as potential safeguarding concerns and residents did not have safeguarding plans in place. There was no identified Designated Officer for the centre at the time of the inspection to receive concerns or allegations and to ensure all reporting obligations are carried out. These incidents were not notified to the Authority as required by the regulations.

The service had put in place a system to identify hazards and risks in the centre and the inspector found that not all risks in the centre were identified through the risk management process. Risks identified on the risk register updated in August 2018 included challenging behaviour , fire safety, transport and infection control.

However it was found that risks that were evident in the centre in relation to medication errors and safeguarding were not identified on the risk register therefore effective control measures were not in place for the management and review of the impact of these risks on the residents. The risk policy contained templates for the measures and actions in place to control specified risks as required by the regulation but these were not fully implemented in the centre.

There was a comprehensive fire identification and risk analysis of the centre carried out by a competent person. While there was still non compliance's in relation to fire regulations as identified in previous inspections these risks where included on the organisational risk register and an associated program of work had been development which had been prioritised by key criteria and risk based manner. Control measures had been implemented as a short to medium term measure to mitigate against the inadequate fire and smoke containment systems were present in the centre. For example if evacuation times exceeded three minutes this had to be reported to the fire prevention officer who would then reassess the fire risk analysis of the centre and amend areas of priorities within the organisation. The inspector reviewed fire drills completed in the centre and the times recorded were within the control measures guidelines.

There was evidence of routine checks completed daily by staff on escape routes, fire panels, emergency lighting and fire fighting equipment. In addition there was a monthly checklist completed by a staff member nominated as the local fire officer with completed action plans with tasks identified in the audit. As stated in the organisations own policy, quarterly reports reviews of the daily and monthly checklists completed by staff were to be reviewed by the person in charge and services manager but this was not occurring in the centre. Evidence of routine servicing of fire detection, alarm system, emergency lighting and fire fighting equipment had been conducted by an authorised person.The inspector reviewed the emergency and evacuation plans and found that it contained appropriate detail to guide staff in the event of possible emergencies such as fire, flooding, power outage, loss of water and loss of heating. There was provisions available for alternative accommodation in these events.

Staff spoken with were very familiar with, and could demonstrate, the systems in place for the ordering, receipt, prescribing, storage, disposal and administration of medications. There were policies and procedures in place for the management of medication, however the management of medication errors and auditing of medication were found not to be robust. There had been 16 incidents of adverse events reported since January 2018. These errors were similar in nature and whilst identified as an area of concern in the 6 month unannounced visit by the provider, and a tracking system had been implemented by the person in charge , appropriate control measures and corrective actions had not been taken that resulted in an elimination or reduction of errors for the residents. The risk was not identified on the centres risk register. Additionally medication audits had not identified that liquid medication and prescribed creams had past their expiry dates and open dates were not recorded for some medication in order to guide staff as to when that medication would expire.

There was an easy to read information booklet displayed in a communal are of the house which contained the process and procedures for making a complaint. It did not contain a photograph and details of the current complaints officer. The inspector reviewed the complaints log and no complaints had been received by the service since the last inspection.

Residents living in the centre were observed to receive care and support from staff whose interactions with residents were positive, person centre and which promoted their rights and independence. The inspector observed staff communicating with residents in line with their support needs and communication plans of support. For example object exchange, 'First and Then' and providing choices were utilised in communicating with residents. Residents well being and welfare were maintained by a high standard of evidence based care and support. It was especially noted by the inspector that the personal plans and support plans were central to; and reflected the assessed needs of the resident. These were found to be of a high quality and provided staff with the necessary guidance in meeting residents needs.Accessibility was incorporated into the residents plan of care through the 'All about me' folder to further assist the resident the resident with understanding their plans and goals
The personal plans outlined the supports required to maximise
their residents development with individual health, social and personal needs and choices. Personal plans were reviewed regularly with the involvement of the resident, families and multi-displinary input. Allied health services were available to residents on a referral basis and there was evidence of written health professional reviews with interventions and recommendations in place. Staff were observed to follow speech and language therapy (SALT) guidance and protocols in place for feeding, eating, drinking and swallow disorders (FEDS) during the breakfast time meal. There was evidence of person centre goals in place for residents reflecting the wishes and needs of the residents, these were reviewed and updated when completed. Members of the management and staff team who met with the inspector had a clear knowledge and understanding of the individual needs of the residents

The inspector found that the service made improvements on the auditing and review of restrictive practices since the previous inspection, with a reduction in the number and frequency of restrictive practices used. All restrictive practices in place had been authorised by the organisations internal processes, however on a walk-about of the service the inspector found that a locked door had not been identified as a restriction and therefore not notified to the Authority as required. From the sample of residents personal files that were reviewed, residents that required a behaviour support plan had one in place that was underpinned by positive behaviour support and promoted a restraint free environment. This was evident through discussions with the person in charge and staff and through the evidence of close monitoring of any restrictive practices which showed on going reduction in the number of times restrictive interventions were required. Staff members spoken with had a good understanding of support residents with behaviours of concern.

Regulation 10: Communication

Each resident is assisted with and supported to communicate in accordance with their needs and wishes and staff were aware of the different communication needs and supports of residents and ensure these needs are met.

Judgment: Compliant

Regulation 11: Visits

Residents are facilitated to receive visitors in suitable communal and private areas in accordance with the residents wishes.

Judgment: Compliant

Regulation 28: Fire precautions

The building was not adequately subdivided with fire and smoke containment measures.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The residents had a personal plan in place which included an assessment of their health and social care needs and which was reviewed on an annual basis following consultation with the resident and their representatives. The personal plan reflected the needs of the residents as assessed by appropriate health care professionals. Plans were was also reviewed on a regular basis by each resident's key worker and outcomes updated as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behavioural support plans were in place and regularly reviewed. Residents were well supported in line with their assessed needs. A non restrictive environment was promoted.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy in place but some risks in the centre had not been identified, risk rated or reviewed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Out of date medications are not appropriately managed in line with relevant national legislation or guidance

Judgment: Not compliant

Regulation 8: Protection

Five incidents were found to have occurred in the designated centre which met the definitions of abuse as per the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document. The inspector found that neither incident had been appropriately managed in accordance with the aforementioned policy nor the organisations own policy.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Parkview House OSV-0002406

Inspection ID: MON-0021690

Date of inspection: 03/09/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: **In response to the area of non-compliance found under Registration Regulation 7(2)(a) and Registration Regulation 7(2)(b)** • Relevant Forms were submitted to HIQA on 28th Aug 18 • All future notifications will be sent to HIQA in a timely fashion	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The organisation has a policy which details the admission procedure in detail, which was reviewed in June 2016 and is due for review again in June 2019 • The reduction in weekly contributions paid by residents was implemented in January 2018 **In response to the area of non-compliance found under regulation 24:** • New Contracts of Care with the revised charges were supplied and signed by Families between 27th - 29th September 18	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: **In response to the area of non-compliance found under regulation 31 (3) (a):**	

- The PIC will ensure that all restrictive practices are identified in the Quarterly returns to the Authority

- All incidents occurring in the centre will be notified to HIQA in the quarterly reports

- Restrictive procedures relating to physical, chemical or environmental restraint will be reported to HIQA on a quarterly basis

- All future incidents of peer to peer contact which meet the definition of abuse as per the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE 2014) document will be reported to HIQA as a 3 day notifiable incident

Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

- The Organization has in place a procedure to ensure that the recruitment of staff is appropriate to the number and assessed needs of the Residents in the designated centre

- The Registered Provider will continue to ensure they provide the provision of consistent staffing with suitably qualified staff in supporting the Residents in the centre

- The PIC will continue to ensure that a monthly staff roster is in place and this is reflected through a 24 hrs clock shift pattern

- The SMH have a robust protocol in place with regard to screening Agency Staff regularly used including Garda Clearance, Training in Safeguarding of Vulnerable Adults, References, previous experience and training etc

In response to the area of non-compliance found under regulation 15 (5) :

- All documents specified in schedule 2 have been updated and are maintained by the HR department and these are available for review upon request. Confirmation of this regulatory requirement was sent to the Authority following inspection

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- SMH Complaints and Compliments policy was reviewed in February 2018 and the National Advocacy service is identified as a support for Service Users

- Staff within the centre have received training in complaints

- Staff will continue to respond to complaints in line with SMH policy
- Complaints will be a set agenda during Residents weekly meetings

In response to the area of non-compliance found under regulation 34(2)(a) :

- The PIC has included a picture of herself in the accessible version of the Complaints Procedure available for Residents

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- The minor works identified in the previous inspection were completed
- There are regular fire checks completed in the centre and regular maintenance of all fire fighting equipment
- Fire Safety Training has been complete by all Staff members
- Regular Fire Drills are completed with all Residents and recorded including night time drills
- There are accessible fire action notices in the centre to support Staff and Residents in the event fire evacuation is required
- All Residents have a personal emergency evacuation plan

In response to the area of non-compliance found under regulation 28 (1):

- St Michael's House Fire Officer and the Person in Charge of the centre have reviewed and updated the fire safety management systems in place so that there are adequate precautions against the risk of fire in the centre
- St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre, and actions identified are in the process of being implemented

In response to the area of non-compliance found under regulation 28(3)(a):

- The Organisations Fire Officer spoke to the HIQA Inspector and outlined the scope of works due to commence in the first quarter of 2019 to bring the centre into compliance with Regulation 28.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- There is a Risk Management Policy is place to reflect changes in assessment of risk including methodology, updating of risk assessment template and risk register template to ensure that significant risks are identified, managed, tracked and reviewed

- The PIC is trained in the management of risk and will continue to develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies

In response to the area of non-compliance found under regulation 26 (1) (c) (ii) (iii) and (iv) :

- The Person in Charge and the Service Manger will review all the designated centre risks, identify control measures and will allocate a risk rating to each area

In response to the area of non-compliance found under regulation 26 (1) (d):

- The Person in Charge will implement an accident and incident tracker system in the centre for each Resident in order to learn from serious incidents or adverse events involving residents. It will also allow the PIC and staff escalate issues accordingly

- The PIC will ensure all monthly safety audits are carried out and signed within the first week of the month, and actions identified are completed in a timely fashion. The PIC will follow up with the Service Manager to ensure escalation where needed

- The Person in Charge will continue monthly hazard inspections and findings identified will be discussed at staff meetings

- All risks will now be included in the centre's risk register

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

In response to the area of non-compliance found under regulation 29 (4) (b):

- The Organisations Health and Medical Trainer carried out an audit in the centre following Inspection

- There are no high alert medications in this centre

- New local protocols for the management and auditing of medication were agreed and implemented at a Staff meeting on 26th Sept 18

- In future out of date creams and medications will be disposed of in a timely fashion

- Blister Packs of medication have been trialed and found to be successful in the reduction of drug errors
- There have been no drug errors since Aug 18
- Any future trends in relation to drug errors will be listed on the centre Risk Register

In response to the area of non-compliance found under regulation 29 (4) (c):

- The locked door to the small room on the landing used to store medication will remain unlocked
- An additional second locked door has been added to the stock press used to store medication in the room

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- All staff are trained in safeguarding
- SMH have appointed a new Designated Officer as of Oct 18

In response to the area of non-compliance found under regulation 08 (2):

- The 5 incidents referred to have been retrospectively notified to HIQA and the HSE
- There are safeguarding plans in place for the Residents involved
- Positive Behaviour Support plans have been reviewed and updated for those who need them
- All risk assessments have been updated

In response to the area of non-compliance found under regulation 08 (3):

- All future incidents of peer to peer contact which meet the definition of abuse as per the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE 2014) document will be reported to HIQA as a 3 day notifiable incident
- The PIC will report any such issues to the Line Manager and Principal Social Worker as per the SMH Policy for Safeguarding Vulnerable Adults
- The Principal Social Worker will notify the Designated Officer and the HSE where required

Section 2: Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 7(2)(a)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre has ceased to be in charge.	Not Compliant	Yellow	28/08/18
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Yellow	12/09/18
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	03/09/18
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	29/09/18
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the	Substantially Compliant	Yellow	31/07/18

	following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	24/10/18
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	31/07/18
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/11/18
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/03/19
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/19
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	26/09/18

Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	02/11/18
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/10/18
Regulation 34(2)(a)	The registered provider shall ensure that a person who is not involved in the matters the subject of complaint is nominated to deal with complaints by or on behalf of residents.	Not Compliant	Orange	04/09/18
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Yellow	30/09/18
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30/09/18